Strategy Research Project

LEVERAGING NATIONAL HEALTHCARE REFORM TO IMPROVE ARMY NATIONAL GUARD READINESS

BY

COLONEL DAVID BRECKENRIDGE SPROAT
United States Army

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U.S. Army War College, Carlisle Barracks, PA 17013-5050

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by

Colonel David Breckenridge Sproat
United States Army

Colonel Roberto Nang
Project Adviser

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U.S. Army War College
CARLISLE BARRACKS, PENNSYLVANIA 17013

ABSTRACT

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National health care reform provides the Department of Defense with a unique opportunity to revise the Defense Health Program to improve the medical readiness of Army National Guardsmen while decreasing long-term health care costs. After discussing the organizational culture of the Guard and the barriers this culture creates to medical readiness, this paper describes the challenges of operationalization and past strategies utilized by the National Guard Bureau to improve medical readiness. Following a review of the national health care environment and reform proposals, this study will suggest policy changes to TRICARE to incorporate the value-based design and the individual health insurance mandate embedded in current legislation. Specifically, monitoring Soldier use of TRICARE Reserve Select (TRS) to meet the health insurance mandate and changing the TRS benefit by developing incentives for healthy behaviors and eliminating cost sharing for preventive services, will help control health care costs while improving readiness. Regardless of the outcome of the current

national debate, leveraging these aspects of proposed legislation and the unique culture of the Guard to implement change will result in a more medically ready, cohesive force.

LEVERAGING NATIONAL HEALTHCARE REFORM TO IMPROVE ARMY NATIONAL GUARD READINESS

Since 1636, the Army National Guard has served its communities in times of need, and the nation in times of war. In 2005, over 40% of Army troop strength in Iraq was contributed by the Guard.[1] In order to meet the force requirements of the current operating environment, the Guard must transform from a strategic reserve to an operational force. This transformation requires not only new ways of manning, equipping and training the force, but fundamental changes in the culture of the Guard. Failure to address these issues puts at risk not only the war effort, but the cohesion of the Guard as a community-based fighting force.

Medical readiness, a key component of manning, continues to be a significant challenge for the Army National Guard (ARNG). Cultural barriers to medical readiness must be overcome in order to operationalize the Guard. Additionally, unlike their Active Duty peers, traditional Guardsmen have the same issues accessing healthcare as many Americans. National health care reform provides the Department of Defense (DoD) with a unique opportunity to revise the Defense Health Program (DHP) to improve the medical readiness of Army National Guardsmen while decreasing long-term health care costs for the American people.

After discussing the organizational culture of the Guard and the barriers this creates to medical readiness, this paper will describe the challenges of operationalization and past strategies utilized by the National Guard Bureau (NGB) to improve medical readiness. Following a review of the national health care environment and reform proposals, this paper will suggest policy changes, incorporating into

TRICARE the value-based design and facilitating the individual health insurance mandate embedded in current legislation. Leveraging these aspects of national healthcare reform and the unique culture of the Guard to implement change will result in a more medically ready, cohesive force.

Organizational Culture

The culture of the Guard is rooted in its nearly 400 years of existence.[2] This heritage and maturity of beliefs underlies a unique culture which is positive and distinct from the Army, but can also create significant barriers to change.[3] In his cross-sectional study of nearly 3000 Guard and Regular Army Soldiers and leaders, Joseph Galioto identified significant similarities between the cultures of the Army and the Guard. However, he also identified attributes that were more highly associated with the Guard: loyalty to the unit and organization, and putting Soldiers, unit, or nation before self.[4] These traits reflected a cultural cohesiveness that was consistent with the community-based nature of the Guard, which he described as its center of gravity.[5]

However, cultural cohesion can also create significant barriers to medical readiness, as it favors relationships over qualifications.[6] As a community-based organization, many Guardsmen already have established relationships outside their Guard affiliation, though school, work, or family. Rather than leveraging these relationships to take care of Soldiers by improving their medical readiness, it fostered a sense of complacency. Guard leaders would not put cohesion at risk by holding Soldiers accountable.

Like the Army, the Guard's emphasis has been on people rather than equipment, and thus its basic measure has been and end-strength.[7] However, as a community-based force, where the individuals may have known or be related to one another, Guard

units have had a much more direct role in maintaining end strength through local recruiting and retention. The constant struggle with, and sensitivity to end strength led leaders to hesitate in enforcement of medical readiness standards.[8] In contrast, the Air Force and Navy required their service members to be fully medically ready in order to be paid for annual training, thus making medical readiness a condition of employment. These reserve components enforced this despite significant out-of-pocket costs to their service members.[9] Guard leaders have expressed fear that Guardsmen would leave the service rather than pay (able or unable) for their own medical and dental care, negatively impacting end strength. The Guard thus turned a blind eye to medical readiness.

Historically, the nation relied on the National Guard as a strategic reserve.[10] As a strategic reserve, the Guard had limited resources and utilized tiered readiness for its units.[11] Soldiers and units expected long periods of training and certification after mobilization to ensure readiness to deploy.[12] Limited time and funding were available at home station for medical readiness activities, leading to an underlying cultural assumption that any Soldier's medical or dental issues would be "fixed at the mobilization site."[13]

This Guard culture, built on cohesion over qualifications, with emphasis on end strength and the expectation of limited resources, resulted in the worst levels of medical readiness in the Department of Defense (DoD).[14] The lack of readiness became a significant barrier to integration with the Active Component.[15] Over half of Guardsmen required significant medical or dental treatment in order to qualify for deployment, leading to tremendous resource expenditures at the mobilization station. More

importantly, this treatment detracted significantly from collective training time, negatively impacting unit cohesion, lengthening the training phase, and delaying deployment of Guard units to theater.

Furthermore, Guard units reporting to mobilization station routinely lost over 5% of their strength due to medically non-deployable Soldiers.[16] These units then needed new Soldiers to fill their requirements, necessitating cross-leveling across units.[17] This cross-leveling was, in effect, cannibalization of other units, which created a domino effect of unready units across the Guard.[18] This organizational shift from deploying units to providing individual cross-levelers put at risk the most important cultural aspect of the Guard: its cohesion as a community-based force.[19]

Operationalizing the Guard

In January 2007, in response to increasing force requirements and the continued need to rely on the reserve components, Secretary of Defense Gates directed the transformation of the Guard from a strategic reserve to an operational force.[20] Rather than having extended periods at mobilization stations to address medical readiness issues, reserve component unit mobilization would be limited to a total of 12 months. In order to maximize “boots on ground” time in theater, units had to arrive at the mobilization station fully medically ready to deploy. Issues that were previously left to “fix at the mobilization site” had to be addressed at home station and certified complete before mobilization.[21] More than any single action, this mandate for change raised the level of urgency, greatly enabling change in the Army National Guard.[22]

The organizational structure of the Guard contributes to its unique culture and presents both barriers to and opportunities for change. The Guard has been described as “54 separate combatant commands,” as a state or territory’s Adjutant General (TAG)

exercises authority independent of the NGB.[23] These differentiated subcultures can prove exceedingly difficult to align.[24] However, if able to attain coherence, the power of their directed energies can be harnessed.[25] At NGB, the goal of the ARNG Chief Surgeon's office was to leverage the energies at the state level to facilitate cultural change, now that the culture had been "unfrozen" by the Gates memo.[26]

The lack of direct NGB authority over the states necessitated a more collegial relationship, increasing the opportunity for dialogue and learning.[27] Initially, for both the state and mobilization platform, preparing the first brigade to mobilize after the Gates memo was an exercise in learning through trial and error.[28] The Chief Surgeon's office, as the learning leader, became the clearinghouse for communications between the states and mobilization platforms of the successes and pitfalls of home station mobilization.[29] NGB transferred funds to the states to enable them to provide the required screenings and dental treatment. As the first unit under the new rules, the Oklahoma Army National Guard's Brigade Combat Team and the mobilization station at Fort Bliss became the role model for imitation by subsequent states, units, and platforms. Change in culture came quickly in each state as they unlearned old behaviors and built on the success of their fellow states.[30] State-level resistance was overcome due the Chief Surgeon's office efforts to minimize learning anxiety through the development of home station mobilization planning tools. Internet-based resources facilitated timely and comprehensive planning through utilization of easily completed templates for proper home station mobilization screening. Survival anxiety (unsuccessful mobilization) became greater than learning anxiety, enabling change.[31]

Communication of a leader's vision is the first step in organizational change.[32] Communicating vision not just to state medical teams, but other stakeholders became the engine for cultural change that enabled successful home station mobilization readiness.[33] Strategic communication on medical readiness was delivered to multiple audiences by different messengers over time and space.[34] Given the appropriate guidance and resources, the state medical teams became "early adopters" of home station medical readiness, often dragging state and unit leadership along. Tracking and widespread visibility of Unit Status Report (USR) indicators became a powerful tool to enforce behavioral change.[35] Mobilization readiness was non-negotiable, and highlighting the examples of peers that were successful or unsuccessful was usually all that was necessary to bring line leaders into compliance.[36]

With adequate funding and a new culture of mobilization readiness at the state level, Guard unit dental deployment readiness at the mobilization station improved remarkably, from 52% in FY06 to 92% in FY08. This enabled unit commanders to focus on collective training at the mobilization station, increasing unit cohesion and boots-on-ground time in theater. Without the Gates mobilization policy forcing this cultural change, it is unlikely that the Guard would have transformed.

Unfortunately, while states have deployed units successfully utilizing home station mobilization, baseline readiness of Guard Soldiers remains poor. Although the culture of "wait until the mobilization station" has changed for units identified in the Army Force Generation (ARFORGEN) cycle, traditional attitudes favoring relationships over qualifications continue to hinder the baseline readiness of the Guard force. States and territories that have not deployed large formations are slow to embrace cultural change

and continue discovery learning. Despite new programs funding dental treatment for Guardsmen throughout ARFORGEN, and historically low premiums for enrollment in the TRICARE Reserve Select medical insurance program, leaders continue to fear enforcing readiness standards due to a perceived risk to end-strength. DoD Instructions and the USR readiness requirements have failed to change Guard culture sufficiently to improve its baseline readiness.[37]

In the absence of these effective external motivators to change, the Guard must rely on the most deeply held beliefs in its culture.[38] As noted by Galioto, the Guard's cultural strength lies in its community-based unit cohesion and dedication to service to others. Future programs, policies and strategic communications must emphasize the cognitive dissonance between the espoused value of taking care of Soldiers, and the current theories in use which devalue medical readiness.[39] Basing the need to change on cohesion and community values will in turn impact readiness. Leaders must clearly understand that cross-leveling due to medically non-deployable Guardsmen, rather than medical readiness enforcement, is the biggest threat to cohesion, the center of gravity for the Guard. They must embrace that Soldiers, as the Guard's most important "weapon system," deserve at least as much dedicated attention as vehicles.[40]

Motivated by the current operating environment, the Army National Guard has overcome its traditional cultural barriers in order to deploy medically ready units. The Guard must now leverage this success to truly change its medical readiness culture, improve the baseline medical readiness of all Guardsmen, and complete the transformation from a strategic reserve to an operational force. The current momentum

for national healthcare reform provides a unique opportunity to springboard towards this goal.

Healthcare Reform

In every decade since the administration of Theodore Roosevelt, some type of health care reform has been on the American political agenda.[41] Roosevelt was the first to advocate national health insurance as part of his progressive platform.[42] FDR initially included national health insurance in his Social Security Act proposal, but withdrew it when it risked its passage.[43] President Truman proposed increasing Social Security tax withholding by 4% to fund national health insurance, but this was defeated by the Republican Congress.[44] In 1961, President Kennedy proposed what would become Medicare and Medicaid under the Johnson administration.[45] Finally, in 1971, Senator Edward Kennedy introduced his first of many proposals for national health insurance.[46] However, neither President Nixon, subsequent administrations, nor Congress supported it.

Candidate Bill Clinton identified health care reform as one of the key issues of his 1992 campaign. Upon election, he convened a commission which recommended reforms to include: mandating employers to provide health insurance to employees; creating regional purchasing alliances to enable the self-employed and uninsured to obtain insurance at group rates; and eliminating denial of coverage for preexisting conditions.[47] However, the Clinton commission excluded key stakeholders in health reform – physicians, insurers, pharmaceutical manufacturers, employers, and the media. This sleight enabled these groups to develop significant public opposition to the Clinton plan even before it was publically announced, and Congress refused to act on the president's proposal.[48]

In the election of 2008, both candidates embraced the need for reform, reflecting the 70% of voters who expressed a need for complete overhaul of the system.[49] Voters were increasingly frustrated with the drastic increases in health care costs, as experienced through their health insurance premiums and cost-sharing. Americans perceived erosion of health care value, defined as the quality of care received for a given cost. Controlling health care costs and improving the value of health services are the focus of the current national health reform agenda. The current health care reform environment and legislative proposals provide a unique opportunity for changing the Defense Health Program. Within the DoD, policy changes implementing value-based health care design (increasing the amount of heath care gained relative to the amount spent) can improve readiness while controlling cost growth.

For the past 30 years, health care costs have on average grown 2.5% faster than the Gross Domestic Product (GDP).[50] In 2008, health care expenditures were 18% of GDP, and at current growth rates are expected to make up 34% of GDP by 2040.[51] For the first time, Medicare expenditures exceeded Medicare tax revenues in 2007. At current rates, the Medicare Part A Trust Fund will be exhausted by 2019.[52] By 2045, Federal health expenditures are projected to exceed all revenue sources.[53] Unconstrained health care cost growth makes U.S. businesses less competitive in an increasingly globalized economy, hinders national economic growth, and puts national solvency at risk.[54]

As federal health care expenditures grow, monies available for the Department of Defense (DoD) and other discretionary spending decrease. Over time, defense spending will be required to decrease to accommodate increasing entitlements and

maintenance of the federal debt.[55] Within the DoD, growth of the Defense Health Program (DHP) budget parallels that of the nation. The vast majority of DHP funding falls under the DoD Operations and Maintenance (O&M) budget.

(Billions)	FY00[1]	FY05[1]	FY06[1]	FY07[1]	FY08[1]	FY09[2]	FY10[3]
DoD O&M	$108.7	$179.2	$203.5	$240.3	$256.7	$276.2	$185.7
DHP O&M	$11.7	$17.7	$20.3	$22.8	$23.9	$24.6	$27.0
	10.7%	9.8%	9.5%	9.4%	9.3%	8.9%	14.5%

[1]Actual
[2]Estimated
[3]Base only

Table 1: DoD and DHP O&M funding for FY00, and FY05 through FY10.[56,57]

As illustrated in table 1, both DoD and DHP budgets have more than doubled during the current conflict, and it would appear that DHP growth mirrors that of the DoD. However, the majority of budget growth for the DHP has been the consequence of the creation of TRICARE for Life (TFL) in the 2001 National Defense Authorization Act (NDAA), which eliminated premiums and cost-sharing for Medicare eligible military retirees.[58] Without cost-sharing, utilization can be expected to continue to increase over time.

When the current conflict inevitably winds down and the DoD budget shrinks, DHP expenditures will take an increasing share of DoD O&M funds – as can be seen for FY10 above. The 2007 Task Force on the Future of Military Health Care projected a total DHP budget of $68 billion in FY15, consuming 8-12% of the total DoD budget.[59] As military medical benefits are congressionally mandated entitlements, in a fiscally constrained environment, the growth in DHP expenditures will necessarily crowd out DoD discretionary spending for manning, equipping and training the force, potentially limiting the nation's military strategic options.

Despite these high costs, the American health industry delivers fragmented care with less than desirable outcomes. Although America spends 50% more than the next

highest country, Switzerland, it ranks 46th in lifespan and 60th in infant mortality.[60] The World Health Organization ranks the U.S. 37th for overall health quality.[61] While nearly 50% of deaths are due to preventable causes, preventive services are underutilized and fraught with racial and gender inequalities.[62] Senator Harkin has stated that America has a sick-care rather than a health care system.[63] Administrative overhead is 14% in the private insurance market, compared to 2% for Medicare and Medicaid.[64] Peter Orszag, Director of the Office of Management and Budget (OMB) has estimated that $700 billion are wasted annually in the American health care system.[65]

In addition to this waste, forty-seven million Americans are uninsured and 25 million underinsured.[66] There is great variation in insurance coverage, with a high of 90% in Minnesota and a low of 73% in New Mexico.[67] The uninsured fall predominantly into two groups: low wage workers and healthy young adults. Twenty-five percent choose to be uninsured.[68] Fully half of the uninsured are thought to be able to afford insurance.[69] The remainder has an income too high to qualify for Medicaid but too low to afford private insurance, or has a pre-existing condition.[70] As a true reflection of America, 20% of reserve component (RC) service members are uninsured, including a third of junior enlisted.[71] The U.S. is the only wealthy industrialized nation without universal healthcare.[72]

American health behaviors also contribute to the spiral of increasing health care costs. Fully two thirds of Americans are overweight or obese, a 47% increase from the 1960's.[73] The obese spend 42% more in health care consumption than their non-obese peers.[74] Obesity related expenditures are responsible for 27% of the increase in health care costs from 1987 to 2001, with total costs estimated at $117 billion per year.[75,76] The

fourfold increase in childhood and adolescent obesity puts the future health of both the nation and its citizens at risk.[77]

Despite a culture of fitness, the military is facing its own challenges with health behaviors. In one study, 60% of men and 40% of women in the Army had body mass indices (BMI) greater than 25, and thus are considered overweight.[78] Among new military recruits, 20-30% of males and 30-50% of females were too overweight for enlistment (the range being due to service-specific requirements).[79] Hispanic men and African-American Women were at the highest risk for disqualification for being overweight.[80] At 32%, the Army National Guard has the highest prevalence of smokers of any service or component, and is well above the national average of 21%.[81] In training impacts alone, smoking costs the military more than $130 million a year.[82]

In response to these challenges, states, businesses, and the insurance industry have embraced value-based design (VBD). VBD seeks to increase the amount of heath care gained relative to the amount spent, and has four main components: adjusting cost-shares to reflect clinical benefit; reducing cost-shares for those at highest risk; incentives for behavioral change; and data collection to study outcomes.[83] It is estimated that 40% of employers are developing incentives for healthy behaviors.[84] As an example, the Tribune Company has instituted premium increases of $100 per month for employees or family members who smoke. Scotts Paper Company requires all employees to complete a Health Risk Appraisal (HRA) or forfeit $40 per month. The Principle Financial Group has mandated employees to improve their lifestyles or risk an increase in cost-sharing.[85] Destiny Health corporation rewards compliance with healthy

lifestyle guidelines with higher interest credits in the employee's health savings account.[86]

Safeway has had the most measurable success with VBD. Their health care costs remained flat from 2005 to 2009 when industry costs increased 38%, despite providing 100% coverage for preventive services such as mammograms, colonoscopy, and well-child examinations.[87] Seventy-four percent of their employees have volunteered to participate in their program, which measures smoking, obesity, blood pressure and cholesterol and established standardized health goals.[88] Employees who have healthy lifestyles or make adequate progress towards these goals receive a premium rebate of up to 20% - equating to $780 for a single employee or $1560 for a family.[89]

States are also adopting VBD to incentivize healthy behaviors for their populations. Alabama provides a $25 per month premium discount to employees who decrease health risks.[90] Florida gives $125 per year in drug store credits to Medicaid beneficiaries who participate in health promotion activities.[91] In a controversial program in West Virginia, Medicaid beneficiaries were changed to a basic plan which provided only essential services. However, if enrollees signed a contract to improve health behaviors, they received credits in a "healthy rewards" account and increased access to enhanced healthcare services.[92]

Cost savings associated with VBD could be substantial, if the programs are successful. Return on investment for health promotion programs has ranged from $4.73 to $1 for each dollar spent.[93,94] In 1999, it was estimated that a 10% weight loss resulted in a two to seven month increase in life expectancy, and a decrease in lifetime medical

costs of $2200 - $5300.[95] For America's 88 million sedentary adults, a lifestyle change of moderate exercise would result in $77 billion in savings, fully 5% of federal health care expenditures.[96]

While 53% of Americans support the concept of VBD, there are concerns with its application.[97] Through study of purchases in 30 households over 4 years, Richards determined that carbohydrate addiction was the largest contributor to obesity, and questioned the effectiveness of incentives in countering addiction.[98] For low income individuals, who have the highest prevalence of risk behaviors, incentives may be effective in the short term, but less effective over the long term.[99] Health lifestyles are contextually embedded behavior patterns – based on family, culture, socioeconomic status and other factors that may not be easily changed with monetary incentives.[100]

Although premium differences based on behaviors may promote equity and efficiency, ethical concerns also exist.[101] The goal of improving employee and family health is motivated by both beneficence (doing good) and economics.[102] Just as safely features on a car may encourage more risk taking behaviors while driving, by providing a safety net, health insurance can encourage or increase the risk for smoking, obesity, and decreased exercise.[103] Lower socioeconomic groups, as well as junior enlisted service members, are at the highest risk for unhealthy behaviors, and thus can be negatively impacted by monetary coercion.[104] In turn, paternalism by states, employers or insurers can be viewed as either positive or dangerous.[105] In the case of West Virginia, patient advocates decried the complexity of a program which provides services to the most vulnerable health and literacy-challenged population.[106] Lastly, in these

programs individual health information is being utilized by employers and insurers, raising privacy concerns.[107]

Current privacy law limits the scope and potential impact of VBD policies. While the intent of the Health Insurance Portability and Accountability Act (HIPAA) was to standardize financial transactions, it is better known for its privacy protections. HIPAA allows a premium discount of up to 20% for participation in health promotion programs.[108] Employers and insurers would like to see the limit on rebates increased to 50%, as the external costs (in increased premiums to all insured) of obesity and smoking are estimated at $150 and $1400 per person per year, respectively.[109] Further theoretical concerns of discrimination exist, however no suits have been won against VBD programs under the Americans with Disabilities Act.[110]

As with VBD, states have taken the lead in tackling the problem of uninsured Americans. The landmark individual health insurance mandate enacted in Massachusetts in April 2006 is serving as a model for national health care reform. Insurance mandates are thought to stabilize private insurance markets, compel rational decision making by consumers, and reduce freeriding.[111] The Massachusetts mandate forces individuals and families to show proof health insurance or face potential tax penalties equal to the lowest insurance premium in the state's insurance pool.[112] A state agency, the Commonwealth Connector facilitates the buying, selling, and administration of private health insurance for individuals and families.[113] This system mirrors successful systems in the Netherlands and Switzerland, where, like America, both private insurers and the government fund the health system.[114] Mandating health insurance increases the size of the pool, forcing young, healthy individuals to enter the premium pool to bear

their proper share of community risk.[115] This decreases the risk to insurers of adverse selection of high risk individuals, enabling the elimination of exclusions for pre-existing conditions. Such mandates also facilitate VBD, as insurers in the aggregate have a long-term interest to maintaining a healthy population, thus reducing costs.[116] The residents of Massachusetts backed the mandate at its inception, and support has grown each year.[117] Massachusetts has expanded health insurance coverage to 355,000 previously uninsured people, demonstrating a feasible, acceptable and suitable course of action for the nation.[118]

The 2008 election result has been interpreted by political leaders as a mandate for health care reform. Both houses of Congress and the administration have embraced universal health care insurance and value-based design as core principles. The House bill includes an individual health insurance mandate with a penalty up to the lesser of 2.5% of modified adjusted gross income (MAGI) or the cost of the average health insurance. It also defines an essential benefits package containing recommended preventive services without cost sharing – key elements of VBD.[119]

As part of the Department of Health and Human Services, the US Preventive Services Task Force (USPSTF) is charged with evaluating the benefits of individual health services and makes evidence-based recommendations on those preventive services that should be incorporated into routine care.[120] Incorporating USPSTF recommended preventive services into legislated private and federal health care coverage, without cost sharing, would serve to greatly increase access to these services in those populations most at risk. Decreasing cost sharing for preventive

services has been shown to increase use, improve health, and decrease costs in the long term.[121]

Similar to the House, the bill passed in the Senate contains individual health insurance mandates and requires coverage of preventive services without cost-shares.[122] However, the Senate bill goes further to embrace VBD by authorizing $200 million for pilot studies of health behavior change incentives for Medicare and Medicaid beneficiaries.[123] This bill also proposes additional taxes on alcohol-containing beverages and new taxes on beverages containing refined sugars, thought to be one source of the nation's obesity epidemic.[124] However, neither the House nor the Senate bills directly address the Defense Health Program, nor its health benefit program, TRICARE.

In 1956, Congress created the Military Health System (MHS), which is charged with providing health care to service members, military retirees and their families.[125] The MHS includes both military health care facilities, as well as the means to reimburse for care provided to beneficiaries through the civilian medical community – a program which would evolve to become the current TRICARE benefit. TRICARE Reserve Select (TRS) was established in 2005 to provide health benefits to RC service members and their families.[126] Until TRS enrollment became available, RC service members were only eligible for care on active duty or to care for injuries or illnesses that occurred in the line of duty.[127] By law, with TRS the service member pays 28% of the total healthcare premium, which is indexed to the growth of premiums for the Federal Employees Health Benefit Program (FEHBP).[128] For FY10, the enrollment fee is $50 per month for the service member or $197 per month for the service member and family.[129] Even with associated deductibles and co-pays, TRS is a tremendous value compared to civilian

health insurance, and the program has grown to $600 million in 2009.[130] Although preventive services are covered benefits in TRS, cost sharing is required.

Policy Proposals Leveraging Healthcare Reform

The current health care reform environment provides the opportunity to facilitate universal health care coverage for Guardsmen and modify the TRICARE benefit to incorporate the principles of value based design. The remainder of this paper will outline three policy proposals to leverage the momentum of current reform environment and the culture of the Guard to improve readiness and decrease long term cost growth of the DHP budget.

First, legislation should be proposed that would modify TRICARE to eliminate cost sharing for USPSTF recommended preventive services, consistent with current health reform legislation. Similar to their Active Component colleagues, Guardsmen are required to undergo an annual Periodic Health Assessment (PHA).[131] However, when preventive services are recommended in the PHA (e.g. cervical cytology for young, sexually active women), these are currently not covered. They are the responsibility of the service member, who may or may not have insurance. The Guardsman must either depend on civilian insurance, TRS (if enrolled) with associated cost sharing, or pay out of pocket. Reticence or inability to pay leads the Soldier to delay or forgo care, increasing the risk for development of cervical cancer (in this example), and resulting in decreased military readiness overall. Female service members are screened prior to mobilization, and unexpected cervical pathology is a leading cause for failure to deploy.

This scenario is repeated daily at mobilization platforms, for a variety of medical issues that could have been identified had appropriate preventive services been

performed. Individual disqualifications necessitate cross-leveling, decrease unit cohesion and negatively impact collective training.

Elimination of cost sharing for preventive services in TRS will increase compliance with PHA recommendations and improve individual service member readiness for deployment. Individual readiness aggregates to collective ARNG readiness as an operational force. To remain cost neutral to the government, the rate structure for TRS could be adjusted to offset the expense of eliminating cost-shares for preventive services.

In addition to improving the readiness of operational forces, this proposal has potential cost benefits for the future. Not every Guardsman will choose to remain in the service and be eligible for TRICARE retirement benefits at age 60. However, prevention and early diagnosis are cost-saving in the long term. Although these savings may not be captured by the DHP, the savings for those that retire will be significant. For those who do not retire or continue to use the military health system, the savings should be recouped by the government when they become Medicare eligible at age 65.

Second, in order to maximize the effect of value based design, legislation should be passed to enable TRICARE to develop health behavior incentives as allowed by HIPAA. Using data from the PHA on weight and smoking, service members should be offered monetary incentives to make lifestyle changes – such as reducing or waiving the $50 per month enrollment fee in TRS. Changes in health behavior could greatly decrease the prevalence of smoking and obesity-related disease in the Guard, improving medical readiness for deployment. These behavior changes should significantly lower health care costs for these individuals, both within the DHP, and the

nation at large. Again, to remain cost neutral to the government, the rate structure for TRS could be adjusted to offset the expense of providing these incentives.

Lastly, to ensure that every Guardsman has health care coverage, enrollment in TRS could be made automatic, but declinable upon proof of health insurance. As noted previously, twenty percent of RC service members lack health insurance, including a third of junior enlisted members. Historically, home station pre-mobilization screening has identified many Soldiers with easily repairable orthopedic issues. Lack of insurance prevents service members from addressing issues that prevent deployment, leading to a permanent population of non-deployable Soldiers. Like Servicemember's Group Life Insurance (SGLI), automatic enrollment in TRS would increase participation rates, particularly in those least likely to participate, facilitating the treatment of deployment limiting medical conditions in this at-risk population.[132] However, if individual insurance mandates in proposed national legislation are adopted universal health care coverage for Guardsmen could be achieved without automatic enrollment.

Nevertheless, there are potential pitfalls to these proposals. Although auto-enrollment in TRS would likely result in improved medical readiness, it would also significantly increase DHP expenses without any future cost savings. DoD pays 72% of TRS costs. This subsidized coverage plan risks crowding out private health care coverage, ultimately increasing public costs.[133] The rate of TRS enrollment in Massachusetts has increased significantly compared to other states since the implementation of its health insurance mandate (figure 1, below). The national insurance mandate in current legislation may cause a similar rise in TRS enrollment nationwide, significantly increasing costs to the DoD.

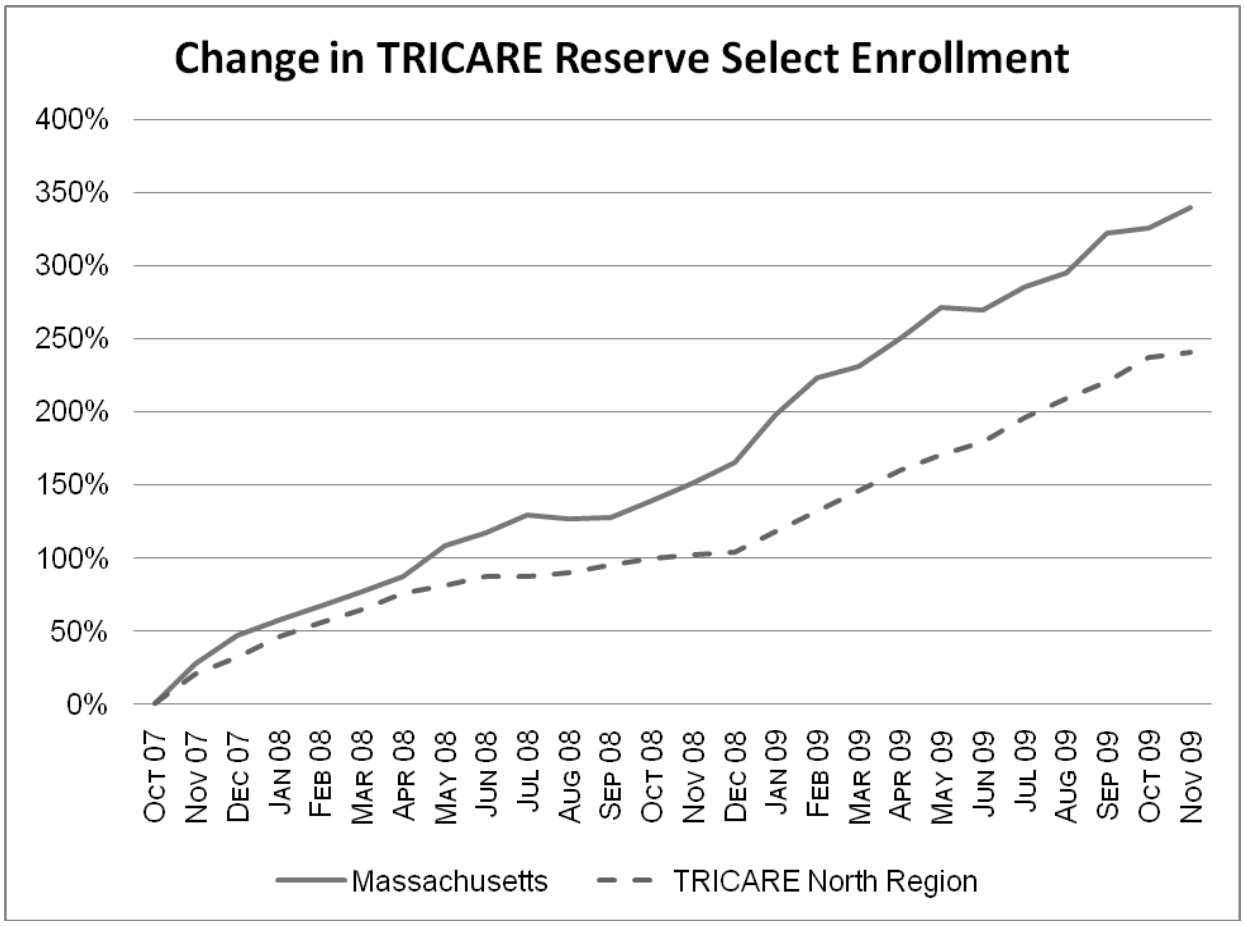

Figure 1. Change in TRICARE Reserve Select Enrollment[134]

Dr. Chu, the former Undersecretary of Defense for Personnel and Readiness understood the risk that rising health care costs posed to the DoD budget, and personally opposed any expansion of TRICARE benefits, despite their potential contributions to medical readiness. In light of this, any proposal for modification of the benefit structure must be cost-neutral in the short term and cost-saving over time.

Similarly, the process of modifying TRICARE benefits is fraught with difficulties. Changes of this magnitude would require new legislation, a procedure that takes years when initiated within DoD. The proposals above also target only reserve component service members. Much greater savings and health benefits would be realized if changes reflecting value-based design also applied to family members and retirees.

However, this may increase opposition to the proposal. As the nation recognizes value-based design's ability to control health care costs, support for comprehensive changes to the TRICARE benefit will develop in congress, the DoD, and among beneficiaries.

Conclusion

Three policy proposals have been made with the potential to improve Guard readiness, ground change in the Guard culture of cohesion, and decrease health care cost growth. The DoD has the opportunity to use the momentum of the current health care reform environment to make fundamental changes to the Defense Health Program and the TRICARE benefit.

Regardless of the outcome of the current health care reform debate, legislation should be proposed to incorporate the principles of value-based design into TRICARE Reserve Select, specifically eliminating cost-sharing for preventive services, and developing incentives for healthy behaviors. These benefit changes can be accomplished without increasing current costs to the DoD, and have the potential for significant cost savings in the future. The DoD should monitor the adoption and implementation of the individual health insurance mandate to facilitate universal health coverage of Guardsmen, while closely tracking enrollment in TRS. Together, these changes will improve baseline readiness, decrease cross-leveling, and increase cohesion in the Guard – its most important cultural attribute.

General Von Steuben wrote that a commander's greatest responsibility is the preservation of Soldier health.[135] Guard leaders must leverage the changes proposed above to improve the health and well-being of their Soldiers. We owe our Guardsmen nothing less.

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